transverse, was evidently supplied with a sphincter, as the child had three or four well controlled movements daily. Anal depression was present and the vulva and vagina were normal, except as noted. The presence of uterus was normal or otherwise not demonstrated. There was no distension of rectum, no impulse and no prominence in perineum. The child was well nourished and otherwise normal. Operative interference postponed. The child is at present well and is 13 months old and weighs 22 pounds.

While this defect is sometimes seen, many cases reported, as atresia and vaginalis, are no doubt in reality imperforate anal canal with vulvar outlet, a malformation admittedly of common occurrence.

Cases in which intestine opens well up in vagina are not accounted for on embryologic grounds, the two structures being embryologically dissimilar and independent.

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### Pruritus Ani, with Report of Cases.

By DONLY C. HAWLEY, A. B., M. D., Burlington, Vt.

In this discussion I do not refer to cases due to intestinal parasites, errors in diet, etc., in which the pruritus is relieved by proper attention to the causative condition, nor so much to the symptoms as to the pathologic condition of the skin and nerve endings, which condition is pathognomonic.

The nearly constant local cause of pruritus ani is abrasion and ulceration of the anal canal, accompanied by blind sinuses underneath or fissures in the muco-cutaneous lining.

Further, some cases are associated with chronic proctitis, which may be a factor in producing or increasing the anal abrasions or ulcerations.

The treatment I have adopted is as follows:

With the patient well anesthetized, the anal canal is dilated, and the ulceration, together with the sinuses and fissures, are thoroughly cauterized with the Paquelin cautery, and also the entire area of chronic dermal inflammation.

My aim is to destroy ulcerated areas, the thickened and altered skin and the pathologic condition of the terminal nerve fibres.

Case I. S. H. E., aet. 62, came under my observation June, 1908. He had suffered with rectal troubles for 45 years. Twenty years ago he was operated on for fissure or fistula, was not certain which. He has had almost intolerable pruritus for eight years, and for the past year it has been so constant and unbearable, especially at night, that he has become a nervous wreck, and has lost 40 pounds in flesh and has been unable to continue his business.

Diagnosis.—Chronic pruritus ani. The skin was inflamed, soddened and thickened over a large area about the anus, with many deep cracks, and four or five ulcerations and abrasions in anal canal. Treatment as outlined. Result, cure and no return up to present time.

Case II. W. A., male, aet. 38. History of pain in rectum for 20 years, and of severe and intolerable pruritus.

Diagnosis.—Chronic pruritus ani. There was a large ulceration in anal canal and three or four blind sinuses, with an area of white brittle and infiltrated skin with large cracks about anus. Operation, same as in Case No. I. Result, cure.

Other cases less severe have been operated upon during past three years, with satisfactory results. The treatment outlined is not new nor original, having been advocated by Mr. W. Mitchell Banks, and practiced by Mr. Fred C. Wallis. Ball's operation is designed to render anesthetic the skin over the undercut area. The operation described accomplishes the same end and besides destroys lesions in anal canal. The former operation has resulted in extensive sloughing. To the latter no such danger attaches.

### A Paper; Intestinal Stricture Following Ileo-Rectostomy—Report of a Case Was Read.

By FRANK C. YEOMANS, M. D., New York City, N. Y.

J. X., a man 46 years of age, was always strong and well but suffered from severe constipation of many years' standing. In October, 1909, an anterior sigmoidopexy was proposed for "prolapse of the sigmoid." Temporary relief followed, but three months later "peritonitis" developed. The same surgeon operated again, freed numerous adhesions, divided the ileum just proximal to the colon, closed the abnormal end and implanted the oral end of the ileum into the rectum. Relief of the constipation was prompt but when he first consulted Dr. Veomans, in July, 1910, it had returned in an obstinate form with all the symptoms of a marked auto-toxemia superadded.

The proctoscope passed easily, but no opening could be discovered in the rectum or the sigmoid. An excellent radiograph, by Dr. L. G. Cole, proved the colon and sigmoid to be unobstructed.

Concluding that the feces, following the path of least resistance, were accumulating in the colon, Dr. Yeomans did an appendicostomy at the New York Polyclinic Hospital, December 16, 1910. Irrigations through the appendix relieved all symptoms for ten weeks. Constipation and toxemia then returned, however, and he performed an exploratory laparotomy March 14, 1911. The ileum ran down into the left side of the pelvis and was lost in a mass of dense adhesions. A broad lateral anastomosis was made between the ileum, just above the adhesions, and the sigmoid. The patient reacted well from the operation, but developed a double pneumonia, 18 hours later, to which he succumbed on the fifth day. The urine was suppressed the last 24 hours of his life. The bowels moved on the second day, and, thereafter, three or four times daily. At the autopsy no peritonitis was found. The specimen removed, consisting of ileum, sigmoid, and rectum intact, showed perfect union of the recent lateral ileo-sigmoidostomy. The remarkable feature of the old end-to-side ileo-rectostomy was that the opening was so constricted that it would scarcely admit a 16 F. catheter and physiologically amounted to a stricture.

The noteworthy features of the case were: 1. Reverse peristalsis of the colon, evidenced by the large quantities of feces expelled by the irrigations through the appendicostomy. 2. The radiograph was valuable in demonstrating a patent sigmoid and colon, thereby proving that the obstruction was in the small intestine. 3. Failure of the proctoscope to reveal the site of the opening does not discredit the diagnostic value of that instrument but shows the extreme degree of contraction of the opening. 4. The many actions of the bowel signify clearly that the physiological function would have been permanently restored had the patient survived the pneumonia. The practical lesson derived from a study of the case is that lateral anastomosis is superior to end-to-side union, especially in the presence of inflammation.

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### Syphilis of the Ano-Rectal Region.

By LEWIS H. ADLER, Jr., M. D., Philadelphia, Pa.

The author related the history of two cases of syphilis in which no outward visible effects of the patient's grave condition existed, except about the anus. In both instances, the anus was surrounded by syphilitic condylomata; the parts were bathed in a fetid sero-purulent discharge and the patients' mouths were affected with mucous patches. In one case the patient was markedly improved by the use of salvarsan and the other one improved under the ordinary mercurial treatment, but disappeared from observation before a cure culd be effected.

The writer then took up the consideration of the usual manifestations of the disease as affecting the localities under consideration, stating that the primary lesion,—always a chancre,—occurs about the anal region much more frequently than is usually